



CEDARS-SINAI®

Thomas M. Priselac
President and CEO

March 4, 2013

Merry Holliday-Hanson, Ph.D., Manager
Administrative Data Program
Office of Statewide Health Planning and Development
400 R Street, Room 250
Sacramento, CA 95811

SUBJECT: Comment Letter on CSMC's Performance on OSHPD Inpatient Mortality Indicators, 2010-2011

Dear Dr. Holliday-Hanson:

The center of Cedars-Sinai's mission is to provide high quality patient care, and inpatient mortality has long been monitored as a key indicator of that quality. As shown by the data on Inpatient Mortality Indicators compiled by the Office of Statewide Health Planning and Development (OSHPD), our many initiatives to reduce preventable mortalities have been highly effective in patients with the areas of acute stroke and craniotomy, where our risk-adjusted mortality rates are ranked "better than state average."

Based on rankings by the federal Center for Medicare and Medicaid Services (CMS), our initiatives to reduce preventable mortalities in heart failure patients have also proven highly effective. The CMS rankings (from their HospitalCompare website) found that Cedars-Sinai was one of only 8 hospitals in California to have a 30-day mortality rate for heart failure "better than the U.S. national rate" between 2008 and 2011.

The CMS rankings for heart failure are in stark contrast to OSHPD rankings for heart failure, which ranked Cedars-Sinai lower. Based on this disconnect between the CMS and OSHPD rankings for heart failure patients, we conducted a more detailed analysis to identify which ranking was more accurate.

Our analysis identified several aspects of patient care for people with heart failure that the OSHPD ranking did not account for, but which were accounted for in the CMS ranking.

The OSHPD rankings do not appear to fully account for the very high-risk patients that have increasingly come to Cedars-Sinai as a result of our focus in treating the most severely ill heart failure patients. Beginning in 2010, our Advanced Heart Failure Program expanded to deliver higher levels of care to patients with the most severe disease, offering advanced mechanical support devices not available at most other institutions, and significantly expanding our heart

Dr. Holliday-Hanson
March 4, 2013
Page Two

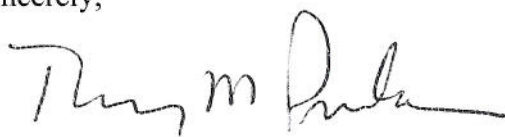
transplantation program to accept sicker patients. Between 2010 and 2011, the proportion of our heart failure patients who received advanced mechanical support or heart transplantation increased by over 20% from 4.4% to 5.3%. As a result, the number of heart failure patients transferred or referred to Cedars-Sinai from other institutions has increased.

In addition, given the higher severity of what is often end-stage disease, many patients eventually change their plan of care to hospice and comfort care as they approach the end of life. Subsequently, most of these patients die in the hospital due to either personal preference or the limited local availability of inpatient hospice beds. Indeed, a significant proportion of our mortalities include patients who received advanced mechanical support (LVAD) during their hospitalization. Those patients comprised a higher proportion of mortalities in 2011 as compared to 2010 (11.5% vs 7.8%).

The risk adjustment methodology used by OSHPD to these data fails to effectively adjust for these clinical factors. The severely ill heart failure patients now being referred or transferred to Cedars-Sinai have a higher risk of mortality. Secondly, unlike the CMS analysis, patients who elect hospice care are included among the mortalities in this OSHPD data. Since Cedars-Sinai is a national referral center for advanced heart failure treatment, a higher proportion of our heart failure mortalities are patients with end-stage disease who have chosen comfort or hospice care during their hospitalization.

It is understandable that risk adjustment methodologies are imperfect, and we appreciate OSHPD's efforts to provide data for comparisons among hospitals. To truly enable patients to make a useful comparison of hospitals, however, the data must reflect all of the factors involved in patient care, accurately adjusted for risk.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas M. Prisela". The signature is fluid and cursive, with a long horizontal stroke at the end.

Thomas M. Prisela